FOR OHF USE

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015032

Facility Name: Washington and Jane Smith Community

Address: 2340 W. 113th Place (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 779-8010 **Fax #** (773) 779-8648

IDPA ID Number: 362167948001

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Stacy L. Koebel **Telephone Number:** (574) 232-3992

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Scott E. Martin, CPA
(Firm Name & Address) Crowe Chizek and Company LLC, 330 E. Jefferson Blvd., P.O. Box 7, South Bend, IN 46624
(Telephone) (574) 232-3992 Fax # (574) 236-8692

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,404	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	185	Sheltered Care (SC)	185	67,710	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	279	102,114	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,039	18,204	2,261	32,504	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	6,301	35,769		42,070	12
13	DD 16 OR LESS					13
14	TOTALS	18,340	53,973	2,261	74,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.03%

D. How many bed-hold days during this year were paid by Public Aid?
22 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/25/1926

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 2,261

Medicare Intermediary Adminastar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	541,474	631	1,856	543,961		543,961		543,961			1
2	Food Purchase		763,917		763,917		763,917	(2,849)	761,068			2
3	Housekeeping	252,948	47,603		300,551		300,551		300,551			3
4	Laundry	92,271	21,656		113,927		113,927		113,927			4
5	Heat and Other Utilities			365,836	365,836		365,836		365,836			5
6	Maintenance	294,136	9,304	219,026	522,466		522,466	(34,439)	488,027			6
7	Other (specify):*			26,760	26,760		26,760	(26,760)				7
8	**TOTAL General Services**	1,180,829	843,111	613,478	2,637,418		2,637,418	(64,048)	2,573,370			8
	B. Health Care and Programs											
9	Medical Director			12,146	12,146		12,146		12,146			9
10	Nursing and Medical Records	2,044,772	69,915	23,964	2,138,651		2,138,651	(1,648)	2,137,003			10
10a	Therapy		10	249,412	249,422		249,422		249,422			10a
11	Activities	284,837	18,427	20,939	324,203		324,203		324,203			11
12	Social Services			1,693	1,693		1,693		1,693			12
13	Nurse Aide Training	4,455			4,455		4,455		4,455			13
14	Program Transportation											14
15	Other (specify):*			1,822	1,822		1,822	(1,424)	398			15
16	**TOTAL Health Care and Programs**	2,334,064	88,352	309,976	2,732,392		2,732,392	(3,072)	2,729,320			16
	C. General Administration											
17	Administrative	182,024		570,369	752,393		752,393		752,393			17
18	Directors Fees											18
19	Professional Services			195,957	195,957		195,957	(10,081)	185,876			19
20	Dues, Fees, Subscriptions & Promotions			14,930	14,930		14,930		14,930			20
21	Clerical & General Office Expenses	957,156	94,972	95,934	1,148,062		1,148,062	(6,008)	1,142,054			21
22	Employee Benefits & Payroll Taxes			1,076,875	1,076,875		1,076,875		1,076,875			22
23	Inservice Training & Education			931	931		931		931			23
24	Travel and Seminar			7,364	7,364		7,364		7,364			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			157,341	157,341		157,341		157,341			26
27	Other (specify):*			26,958	26,958		26,958	(26,958)				27
28	**TOTAL General Administration**	1,139,180	94,972	2,146,659	3,380,811		3,380,811	(43,047)	3,337,764			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,654,073	1,026,435	3,070,113	8,750,621		8,750,621	(110,167)	8,640,454			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington and Jane Smith Community #0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			494,269	494,269		494,269	(11,322)	482,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			161,001	161,001		161,001	9,349	170,350			32
33	Real Estate Taxes			9,583	9,583		9,583	(9,259)	324			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			186,494	186,494		186,494	(169,053)	17,441			36
37	**TOTAL Ownership**			851,347	851,347		851,347	(180,285)	671,062			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		685,623		685,623		685,623		685,623			39
40	Barber and Beauty Shops			46,313	46,313		46,313	(19,921)	26,392			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,045	56,045		56,045		56,045			42
43	Other (specify):*	191,038	121	25,298	216,457		216,457	(214,688)	1,769			43
44	**TOTAL Special Cost Centers**	191,038	685,744	127,656	1,004,438		1,004,438	(234,609)	769,829			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,845,111	1,712,179	4,049,116	10,606,406		10,606,406	(525,062)	10,081,344			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,849)	2		4
5	Telephone, TV & Radio in Resident Rooms	(26,760)	7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(4,590)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,200)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(152,784)	36		24
25	Fund Raising, Advertising and Promotional	(193,811)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,259)	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(143,166)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (535,419)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (535,419)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Washington and Jane Smith Community

ID# 0015032

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Assisted Living - Contract Nursing	$ (1,648)	10	1
2	Resident Transport	(4,327)	6	2
3	Miscellaneous Non-allowable	(505)	21	3
4	Guest Room Income	(3,712)	6	4
5	Office Rent and Utilities	(26,400)	6	5
6	Flowers	(1,424)	15	6
7	Non-allowable Legal Expense	(10,081)	19	7
8	Resident Telephone Income	(380)	21	8
9	Miscellaneous Resident Charges	(533)	21	9
10	Investment Advisory Fee	(24,758)	27	10
11	Apt. - Depreciation	(15,884)	30	11
12	Miscellaneous Bond Expense	(14,940)	36	12
13	Apt. - Bond Interest	(1,009)	32	13
14	Apt. - LOC Fees	(983)	36	14
15	Apt. - Misc. Bond Expense	(346)	36	15
16	Beauty Shop Income	(19,921)	40	16
17	Bldg & Gr Apt - Supplies General	(4)	43	17
18	Bldg & Gr Apt - Yard Maintenance	(1,135)	43	18
19	Bldg & Gr Apt - Repairs & Mtce Equipment	(1,397)	43	19
20	Bldg & Gr Apt - Repairs & Mtce Paint	(320)	43	20
21	Bldg & Gr Apt - Repairs & Mtce Plumbing	(207)	43	21
22	Bldg & Gr Apt - Repairs & Mtce Building	(1,363)	43	22
23	Bldg & Gr Apt - Heating	(367)	43	23
24	Bldg & Gr Apt - Refuse Disposal	(1,222)	43	24
25	Heat Power - Apt Utilities Gas	(11,221)	43	25
26	Heat Power - Apt Utilities Electric	(2,038)	43	26
27	Heat Power - Apt Utilities Water	(1,603)	43	27
28	Depreciation on prior year R&M to fixed assets	4,562	30	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(143,166)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington and Jane Smith Community # 0015032 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,849)	0	0	0	0	0	0	0	0	0	0	(2,849)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(34,439)	0	0	0	0	0	0	0	0	0	0	(34,439)	6
7	Other (specify):*	(26,760)	0	0	0	0	0	0	0	0	0	0	(26,760)	7
8	**TOTAL General Services**	(64,048)	0	0	0	0	0	0	0	0	0	0	(64,048)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,648)	0	0	0	0	0	0	0	0	0	0	(1,648)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(1,424)	0	0	0	0	0	0	0	0	0	0	(1,424)	15
16	**TOTAL Health Care and Programs**	(3,072)	0	0	0	0	0	0	0	0	0	0	(3,072)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,081)	0	0	0	0	0	0	0	0	0	0	(10,081)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(6,008)	0	0	0	0	0	0	0	0	0	0	(6,008)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(26,958)	0	0	0	0	0	0	0	0	0	0	(26,958)	27
28	**TOTAL General Administration**	(43,047)	0	0	0	0	0	0	0	0	0	0	(43,047)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(110,167)	0	0	0	0	0	0	0	0	0	0	(110,167)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Washington and Jane Smith Community** **#** **0015032** **Report Period Beginning:** **07/01/2003** **Ending:** **06/30/2004**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(11,322)	0	0	0	0	0	0	0	0	0	0	(11,322)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,009)	0	0	0	0	0	0	0	0	0	0	(1,009)	32
33	Real Estate Taxes	(9,259)	0	0	0	0	0	0	0	0	0	0	(9,259)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(169,053)	0	0	0	0	0	0	0	0	0	0	(169,053)	36
37	**TOTAL Ownership**	(190,643)	0	0	0	0	0	0	0	0	0	0	(190,643)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(19,921)	0	0	0	0	0	0	0	0	0	0	(19,921)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(214,688)	0	0	0	0	0	0	0	0	0	0	(214,688)	43
44	**TOTAL Special Cost Centers**	(234,609)	0	0	0	0	0	0	0	0	0	0	(234,609)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(535,419)	0	0	0	0	0	0	0	0	0	0	(535,419)	45

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	27	Investment	$ 24,758	Heritage Capital		$ 24,758	$	1
2	V	26	Insurance	189,571	The Orthon Group		189,571		2
3	V	19	Legal Fees	102,294	Quarles & Brady		102,294		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 316,623			$ 316,623	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James J. Nemec	Board Member	Trustee of the	None	None	10	25.00	Financial	$ 24,758	27-03	1
2			Board and Owner					Services			2
3			of Heritage Capital								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 24,758		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle Bank		X	Construction Bond	Various	1991	$ 5,800,000	$ 5,800,000	07/26	Variable	$ 145,347	1
2	Bank One		X	Construction Bond	Various	1997	1,000,000		09/03	Variable	1,009	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,800,000	$ 5,800,000			$ 146,356	9
	B. Non-Facility Related*											
10	Bond Interest-Apt										(1,009)	10
11	Interest on Gift Annuity										15,450	11
12	Clara Eddy-Unrealized Gain										(5,093)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 9,349	14
15	TOTALS (line 9+line14)						$ 6,800,000	$ 5,800,000			$ 155,704	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NA Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Washington and Jane Smith Community **#** 0015032 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington and Jane Smith Community COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT Stacy L. Koebel

TELEPHONE (574) 232-3992 FAX #: (574) 236-8692

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 185,004 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

11248 S. Oakley Avenue - Assisted Living property (costs adjusted out on page 5)

11365 S. Western Avenue - Independent Living apartments (costs adjusted out on page 5)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		247,516	Pre 1994	$ 649,404	1
2					2
3	TOTALS	247,516		$ 649,404	3

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1924		$ 70,920	$		$	$	$ 70,920	4
5	57			1928	438,552					438,558	5
6	55			1958	429,080					429,080	6
7	50			1972	1,528,440	43,670		43,670		1,143,358	7
8	77			1992	4,868,578	139,102		139,102		1,669,226	8
	Improvement Type**										
9	Various			1974	48,223		20			48,223	9
10	Various			1980	102,046		20			102,046	10
11	Various			1981	31,819		20			31,819	11
12	Various			1982	53,600		20			53,600	12
13	Various			1983	163,759		20			163,759	13
14	Various			1984	190,740	9,537	20	9,537		190,740	14
15	Various			1985	26,309	1,315	20	1,315		24,991	15
16	Various			1987	149,405		20			149,405	16
17	Various			1989	232,022	9,004	20	9,004		219,223	17
18	Various			1991	1,131,229	28,999	20	28,999		522,908	18
19	Various			1993	69,928	4,187	20	4,187		48,372	19
20	Various			1994	102,713	5,137	20	5,137		102,713	20
21	Various			1995	270,529	14,000	20	14,000		133,870	21
22	Various			1996	42,902	2,366	20	2,366		21,034	22
23	Various			1997	374,148	33,011	20	33,011		243,122	23
24	Various			1998	378,388	24,927	20	24,927		147,659	24
25	Various			1999	130,547	11,940	20	11,940		58,365	25
26	Various			2000	93,243	6,057	20	6,057		29,252	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,927,120	$ 333,252		$ 333,252	$	$ 6,042,242	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,927,120	$ 333,252		$ 333,252	$	$ 6,042,242	1
2	Vertical Blinds	2001	1,211	242	5	242		969	2
3	Paint 3 floor corridors	2001	6,240	1,248	5	1,248		4,992	3
4	Paint kitchen	2001	3,535	707	5	707		2,828	4
5	Asbestos encapsulation	2001	3,410	341	10	341		1,364	5
6	Replacement Door	2001	1,019	51	20	51		204	6
7	Asphalt repair	2001	2,275	228	10	228		910	7
8	Tub Supplies	2001	919	92	10	92		368	8
9	Tub Supplies	2001	12	1	10	1		5	9
10	Renovations-2nd floor	2001	94	4	25	4		15	10
11	Renovations-2nd floor	2001	1,001	40	25	40		160	11
12	Tub Supplies	2001	1,920	192	10	192		768	12
13	Renovations-2nd floor	2001	25,734	1,029	25	1,029		4,117	13
14	Tenant buildout	2001	3,903	781	5	781		3,122	14
15	Floor covering	2001	1,050	105	10	105		420	15
16	Hydro-flushing of sewers	2001	785	79	10	79		314	16
17	Paint common areas	2001	429	86	5	86		343	17
18	Irrigation system - R&M	2001	665		20	33	33	133	18
19	Paint - R&M	2001	587		20	29	29	118	19
20	Paint - R&M	2001	1,151		20	58	58	231	20
21	Boiler - R&M	2001	704		20	35	35	141	21
22	Shade - R&M	2001	1,037		20	52	52	208	22
23	Carpeting - R&M	2001	3,759		20	189	189	754	23
24	Air conditioning chiller - R&M	2001	1,952		20	98	98	392	24
25	Thermostat - R&M	2001	783		20	39	39	157	25
26	Waterproofing	2001	1,900	190	10	190		760	26
27	Renovations-2nd floor	2001	384	15	25	15		62	27
28	Pre-Contruction Beverly	2001	667	27	25	27		107	28
29	Carpet	2001	4,541	454	10	454		1,816	29
30	Carpet	2001	4,419	442	10	442		1,768	30
31	Smoke Detectors	2001	7,791	779	10	779		2,337	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,010,997	$ 340,385		$ 340,918	$ 533	$ 6,072,124	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,010,997	$ 340,385		$ 340,918	$ 533	$ 6,072,124	1
2	Certification letter for smoke detectors	2001	900	90	10	90		270	2
3	Sealcoat & Parking Lot	2001	3,125	625	5	625		1,875	3
4	Sewer improvements	2001	2,434	97	25	97		292	4
5	Sewer improvements	2001	200	8	25	8		24	5
6	Topography	2001	2,850	143	20	143		428	6
7	Tunnel roofing	2001	2,800	140	20	140		420	7
8	Kitchen door replacement	2001	2,350	118	20	118		353	8
9	Painting Hallway & Nursing Station	2001	5,544	554	10	554		1,663	9
10	Awning for Gregg Entrance	2001	776	78	10	78		233	10
11	Window blinds	2001	3,327	333	10	333		998	11
12	Paint	2002	2,090	105	20	105		314	12
13	Air conditioner	2002	298	30	10	30		89	13
14	Water heater	2002	4,026	403	10	403		1,208	14
15	Generator Repair R&M	2001	775		20	39	39	155	15
16	Security Keypad R&M	2001	1,111		20	56	56	223	16
17	Cabling material & labor R&M	2001	3,973		20	199	199	797	17
18	Painting R&M	2001	2,396		20	120	120	481	18
19	Carpeting R&M	2001	7,063		10	706	706	2,825	19
20	Window shades R&M	2001	1,370		10	137	137	548	20
21	Window Treatment R&M	2001	576		10	58	58	230	21
22	Doors R&M	2001	1,685		10	169	169	674	22
23	Gas valve operator R&M	2001	1,383		10	138	138	553	23
24	Storm damage repair - Roof & Gutters	2002	28,675	1,147	25	1,147		3,441	24
25	115 V pump	2002	1,009	101	10	101		303	25
26	Landscape	2002	2,310	116	20	116		347	26
27	Upgrade fire system	2002	1,645	82	20	82		247	27
28	Painting	2002	12,635	1,264	10	1,264		3,791	28
29	Upgrade kitchen wiring for dishwasher	2002	7,850	393	20	393		1,178	29
30	Paint & Wall removal	2002	9,460	946	10	946		2,838	30
31	Paint	2002	809	81	10	81		243	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,126,442	$ 347,236		$ 349,391	$ 2,155	$ 6,099,163	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,126,442	$ 347,236		$ 349,391	$ 2,155	$ 6,099,163	1
2	Generator fuel tank & pump	2002	1,500	75	20	75		225	2
3	Refurbish Oakley booster pump	2002	1,401	140	10	140		420	3
4	Paint stairwells	2002	982	98	10	98		295	4
5	AL living room	2001	282	14	20	14		42	5
6	AL living room	2001	2,274	114	20	114		341	6
7	AL living room - electrical	2001	1,165	58	20	58		175	7
8	AL living room	2001	5,479	274	20	274		822	8
9	AL living room - paint	2001	741	37	20	37		111	9
10	AL living room - countertops	2001	3,066	153	20	153		460	10
11	Painting - R&M	2002	3,150		20	158	158	474	11
12	Sewage Pump R&M	2002	720		20	36	36	108	12
13	Flag pole R&M	2002	644		20	32	32	97	13
14	Valves & Operator R&M	2002	1,299		10	130	130	390	14
15	Morrison exhaust fan	2002	899	90	10	90		270	15
16	Front door replacement	2002	1,600	160	10	160		320	16
17	Boiler repairs	2002	1,625	163	10	163		325	17
18	Painting	2002	1,275	128	10	128		255	18
19	Morrison sidewalks	2002	4,795	480	10	480		959	19
20	Painting	2002	595	60	10	60		119	20
21	Painting	2002	1,360	136	10	136		272	21
22	Painting	2002	1,050	105	10	105		210	22
23	Drapes	2002	256	26	10	26		51	23
24	Paint & Supplies R&M	2002	513		10	51	51	153	24
25	Paint & Supplies R&M	2002	746		10	75	75	225	25
26	Repair Aurora pump R&M	2002	814		10	81	81	243	26
27	Heavy duty door R&M	2002	2,009		10	201	201	603	27
28	Repair gate R&M	2002	500		10	50	50	150	28
29	Resident room carpeting R&M	2002	1,510		10	151	151	453	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,168,692	$ 349,545		$ 352,665	$ 3,120	$ 6,107,730	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,168,692	$ 349,545		$ 352,665	$ 3,120	$ 6,107,730	1
2	Door locks R&M	2002	528		10	53	53	159	2
3	Pump repair R&M	2002	847		10	85	85	255	3
4	Boiler repair R&M	2002	675		10	68	68	204	4
5	Repair dairy walk-in cooler R&M	2002	1,474		10	147	147	441	5
6	Boiler repair	2003	5,396	540	10	540		1,079	6
7	Fire alarm panel repair	2003	1,947	195	10	195		389	7
8	Painting	2003	3,574	357	10	357		715	8
9	Turn-on lawn sprinkler R&M	2003	896		10	90	90	180	9
10	Turn-on lawn sprinkler R&M	2003	770		10	77	77	154	10
11	Paint & Supplies R&M	2003	1,273		10	127	127	254	11
12	Resident room carpeting R&M	2003	798		10	80	80	160	12
13	Resident room carpeting R&M	2003	506		10	51	51	102	13
14	Resident room carpeting R&M	2003	644		10	64	64	128	14
15	Resident room carpeting R&M	2003	1,257		10	126	126	252	15
16	Replace compressor R&M	2003	1,180		10	119	119	238	16
17	Repair air conditioning R&M	2003	1,769		10	177	177	354	17
18	Repair delfield cooler R&M	2003	1,163		10	116	116	232	18
19	Replace fill valve & drain asse R&M	2003	623		10	62	62	124	19
20	Drapes	2003	2,296	230	10	230		459	20
21	Painting North Entrance	2003	1,880	188	10	188		376	21
22	Painting reception area	2003	1,975	198	10	198		395	22
23	Door security - Patio off main sitting room	2003	6,694	669	10	669		1,339	23
24	Chimney Work	2003	2,720	272	10	272		544	24
25	Tuckpointing - North Courtyard vent	2003	1,380	138	10	138		276	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,210,957	$ 352,331		$ 356,893	$ 4,562	$ 6,116,540	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,210,957	$ 352,331		$ 356,893	$ 4,562	$ 6,116,540	1
2									2
3									3
4	Auditorium Fire Door	2003	1,205	55	20	55		55	4
5	Booster Pump Repair	2003	3,933	361	10	361		361	5
6	Johansen Windows	2003	2,652	111	20	111		111	6
7	Smith NE Flat Roof	2003	8,720	2,422	3	2,422		2,422	7
8	Johansen Roof Coating	2003	7,900	658	10	658		658	8
9	Window Treatments	2003	1,040	156	5	156		156	9
10	Tub & Toilet Floors - Johansen	2003	12,900	968	10	968		968	10
11	Painting Johansen	2003	15,977	2,397	5	2,397		2,397	11
12	Painting Johansen	2003	4,093	546	5	546		546	12
13	Painting Johansen	2004	2,340	195	5	195		195	13
14	Painting Johansen	2004	7,896	132	5	132		132	14
15	Compartment Sinks	2004	1,291	65	10	65		65	15
16	Electrical conduit & wiring	2004	1,957	16	10	16		16	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,282,860	$ 360,411		$ 364,973	$ 4,562	$ 6,124,619	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 698,042	$ 81,115	$ 81,115	$	10	$ 361,656	71
72	Current Year Purchases	56,893	4,624	4,624		10	4,642	72
73	Fully Depreciated Assets	835,274	7,197	7,197		10	835,274	73
74								74
75	TOTALS	$ 1,590,209	$ 92,936	$ 92,936	$		$ 1,201,572	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Facility	1999 Ford Taurus	1999	$ 16,118	$ 1,612	$ 1,612	$	5	$ 8,865	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,191	2,191		5	4,381	77
78	Nursing Facility	2000 Ford Goshen Bus	2000	45,104	3,007	3,007		5	12,028	78
79										79
80	TOTALS			$ 83,127	$ 6,809	$ 6,809	$		$ 25,274	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,605,600	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 460,157	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 464,719	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,562	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,351,465	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Apt	$ 112,500	$	$	86
87	Building Apt	487,975	12,200	91,496	87
88	Building Improv. Apt	127,333	12,769	64,987	88
89	Furniture Apt	31,313	3,115	28,509	89
90	House - Land and Building	321,223	5,933	11,865	90
91	TOTALS	$ 1,080,344	$ 34,017	$ 196,857	91

G. Construction-in-Progress

	Description	Cost	
92	Development of addtl units	$ 1,270,732	92
93			93
94			94
95		$ 1,270,732	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,142 Description: Copier - $13,299 and Postage Meter - $843
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	1,451	$ 99,529	$	1,451	$ 99,529	1
2	Licensed Speech and Language Development Therapist	10a	hrs		78	9,459		78	9,459	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		1,959	139,211		1,959	139,211	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	3,488	$ 248,199	$	3,488	$ 248,199	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 349,030	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,446)	1,057,067		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	7,031,523		5
6	Prepaid Insurance	25,352		6
7	Other Prepaid Expenses	34,872		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,497,844	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	164,500		11
12	Long-Term Investments	224,077		12
13	Land	875,481		13
14	Buildings, at Historical Cost	8,031,190		14
15	Leasehold Improvements, at Historical Cost	4,017,344		15
16	Equipment, at Historical Cost	1,704,650		16
17	Accumulated Depreciation (book methods)	(7,534,296)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Page 17 Supplemental	1,482,105		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,965,051	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,462,895	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 354,757	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,243		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	435,488		30
31	Accrued Taxes Payable (excluding real estate taxes)	62,194		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Page 17 supplemental	414,538		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,277,220	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,800,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Page 17 supplemental	12,254		43
44	Due from related parties	(116,190)		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,696,064	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,973,284	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,489,611	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,462,895	$	48

***(See instructions.)**

Facility Name & ID Number: Washington and Jane Smith # 0015032 Report Period Beginning: 07/01/03 Ending: 06/30/04

Supplemental Schedule of Other Assets and Liabilities As of 6/30/04

	Other Current Assets:	Amount
09A		
09B		
09C		
09D		
09E		
09F		
09G		

	Other current Liabilities:	Amount
36A	403(b)	1,980
36B	Accrued pension	107,754
36C	Escrow liability	48,203
36D	Garnishments	2,460
36E	Gift Annuities payable	15,450
36F	Resident credit balances	237,106
36G	Unclaimed checks	1,585
		414,538

	Other Non-Current Assets:	Amount
23A	Bond Escrow	48,226
23B	Construction in Progress	1,270,732
23C	Net debt issuance cost	163,147
23D		
23E		
23F		
23G		
		1,482,105

	Other Non-Current Liabilities:	Amount
23A	Due to related parties	-
23B	Gift annuities-net of current installments	12,254
23C		
23D		
23E		
23F		
23G		
		12,254

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 56,957,842	1
2	Restatements (describe):		2
3			3
4	Other	14	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 56,957,856	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	101,973	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 101,973	17
	B. Transfers (Itemize):		
18	Transfer net assets to related party	(46,570,218)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (46,570,218)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,489,611	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,460,991	1
2	Discounts and Allowances for all Levels	(1,089,013)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,371,978	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	437,316	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 437,316	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,921	13
14	Non-Patient Meals	2,849	14
15	Telephone, Television and Radio	380	15
16	Rental of Facility Space		16
17	Sale of Drugs	614,854	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,002	19
20	Radiology and X-Ray		20
21	Other Medical Services	304,524	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 943,530	23
	D. Non-Operating Revenue		
24	Contributions	136,617	24
25	Interest and Other Investment Income***	1,918,941	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,055,558	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attachment	2,899,997	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,899,997	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,708,379	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,637,418	31
32	Health Care	2,732,392	32
33	General Administration	3,380,811	33
	B. Capital Expense		
34	Ownership	851,347	34
	C. Ancillary Expense		
35	Special Cost Centers	948,393	35
36	Provider Participation Fee	56,045	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,606,406	40
41	**Income before Income Taxes (line 30 minus line 40)****	101,973	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 101,973	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

XVII. INCOME STATEMENT - Detail of Other Revenue, Line 28

Description	Amount
Discounts earned	$ 5,255
Independent Living Room & Board	935,211
Assisted Living Room & Board	1,627,315
Apartment Rents	129,703
Assisted Living - Special Care	135,149
Resident Transport	4,327
Miscellaneous Resident Charges	533
Guest Room Income	3,712
Other Miscellaneous	32,392
Office Rent and Utilities	26,400
	$ 2,899,997

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,317	$ 78,789	$ 34.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,416	31,399	695,792	22.16	3
4	Licensed Practical Nurses	43,309	44,440	558,166	12.56	4
5	Nurse Aides & Orderlies	134,252	143,235	1,461,001	10.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,474	7,061	92,505	13.10	8
9	Activity Director	2,309	2,317	38,180	16.48	9
10	Activity Assistants	24,503	25,533	235,670	9.23	10
11	Social Service Workers	6,535	6,950	154,286	22.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,750	11,656	154,087	13.22	14
15	Cook Helpers/Assistants	35,295	36,557	324,261	8.87	15
16	Dishwashers	9,472	10,032	106,843	10.65	16
17	Maintenance Workers	28,676	30,724	417,539	13.59	17
18	Housekeepers	16,964	18,195	158,846	8.73	18
19	Laundry	10,118	11,138	95,566	8.58	19
20	Administrator	2,225	2,317	110,059	47.50	20
21	Assistant Administrator	2,139	2,317	57,055	24.62	21
22	Other Administrative					22
23	Office Manager	2,255	2,317	74,948	32.35	23
24	Clerical	27,569	28,730	427,211	14.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,658	2,839	34,697	12.22	31
32	Other Health Care(specify)					32
33	Other(specify) Community Relati	10,922	11,727	139,318	11.88	33
34	TOTAL (lines 1 - 33)	407,873	431,801	$ 5,414,819 *	$ 12.54	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,146	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,321	10-03	39
40	Physical Therapy Consultant	24	1,213	10A-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,340	11-03	44
45	Social Service Consultant	Monthly	1,693	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	24	$ 27,841		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	59	$ 3,212	10-03	50
51	Licensed Practical Nurses	89	3,435	10-03	51
52	Nurse Aides	11	200	10-03	52
53	TOTAL (lines 50 - 52)	158	$ 6,846		53

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Phill Hemmer	Exec Director	0	$ 77,829
David Carrol	Former Exec Dir	0	46,332
Kevin McGee	Associate Exec Dir	0	56,650
Rob Schaffrathe	IT Director	0	3,213
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 184,024

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Service Trac, LLC	Resident/Employee Survey	$ 3,708
Kevin McGee	Kinko's	117
Right Management Consultants	Career Service Outplacement	10,000
C. Scott Robinson & Affiliates	Union Consultant	98,236
Frost, Ruttenberg & Rothblatt	Accounting	21,150
Quarles & Brady	Legal	42,317
Hinshaw & Culbertson	Legal	4,214
LaSalle Bank, N.A.	LOC Fees	5,647
Jones Day	Legal	621
Ameripay	Payroll Services	9,947
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 195,957

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,102
Unemployment Compensation Insurance	7,241
FICA Taxes	362,996
Employee Health Insurance	290,513
Employee Meals	34,727
Illinois Municipal Retirement Fund (IMRF)*	
Tuition Reimbursement	3,639
Employee Appreciation Events	4,695
Life/Disability Insurance	9,634
Pension Expense	242,408
Misc. Employee Benefits	11,920
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,076,875

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,595
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues/Subscriptions	335
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,930

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,510** Line **39**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **56,045**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **34,727** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Crowe Chizek and Company LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.